DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[illegible]	A. BUILDING B. WING ______	12/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT HEALTH AND REHABILITATION CENTER	130 GENERATION DRIVE NEWPORT, TN 37821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	31DEC12 Brian Scott Oliver, SE		*"This Plan of Correction is the facility's credible allegation of compliance."* *"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."*	01/15/2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 01/28/13

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445004	A. BUILDING _____ B. WING _____	12/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT HEALTH AND REHABILITATION CENTER	135 GENERATION DRIVE NEWPORT, TN 37821

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F 000	INITIAL COMMENTS	164	**How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** On 12/11/12, Housekeeping Supervisor changed the privacy curtain surrounding Resident # 60. The privacy curtain is now long enough to enclose the bed to provide full visual privacy. **How will the facility identify other residents as having the potential to be affected by the same deficient practice?** On 12/11/12, the management staff conducted an audit of the privacy curtains throughout the facility. Any curtains that were not long enough to fully enclose the bed were replaced by housekeeping staff. **What measures will be put in place or systemic changes made to ensure that deficient practice will not recur?** The housekeeping staff has been educated by the Director of Environmental Services regarding the requirement for the privacy curtains to fully enclose the bed, to assure that when a curtain is replaced, a proper size is hung. Ambassadors have been educated by Staff Development Coordinator (SDC) to report to the Maintenance Director if a mechanical problem is the reason a curtain will not close and to report to the Housekeeping Supervisor if the curtain is to short, so that measures can be taken to repair or replace the curtain.	01/15/2013
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by:			

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F 164	Continued From page 1 Based on observation and interview, the facility failed to provide full visual privacy during care, for one (# 60) of forty residents reviewed. The findings included: Resident #60 was admitted to the facility on July 17, 2012, with diagnoses including Hypetension, Diabetes Mellitus and Depression. A random observation, in the resident's room, during a medication pass, on December 11, 2012, at 1:43 p.m., revealed the privacy curtain was not long enough to enclose the bed to provide full visual privacy for the resident while care was being rendered. Interview with Licensed Practical Nurse (LPN) #1 at the time of the observation, confirmed the privacy curtain did not close completely to provide full visual privacy while medications were administered to the resident.	F 164 continued	The nursing staff, licensed nurses and Resident Care Specialists was educated by the SDC regarding the requirement for privacy curtains to fully enclose the bed for full visual privacy, when care is being rendered. They were given the same instructions for reporting as the Ambassadors. Education of above target audiences will be complete by 1/15/13. Any staff member not completing education by this date will complete prior to next scheduled shift. Ambassador rounds (conducted Monday – Friday) will include observation of privacy curtains for full bed enclosure. Any found not to be long enough or working properly will be reported to the Housekeeping Supervisor or the Maintenance Director. The Administrator will observe the privacy curtains in 5 rooms weekly for 4 weeks then 5 rooms per month for 2 additional months to assure that privacy curtains fully enclose the beds.	01/15/2013

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How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?

Findings will be reported to the Quality Assurance Performance Improvement Committee (QAPI) for a period of three months or until substantial compliance is determined by the QAPI committee.

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	445394	A. BUILDING _____ B. WING _____	12/14/2012

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F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to assure one resident (#25) was assessed prior to self administration of a medication for one of forty residents reviewed. The findings included: Resident #25 was admitted to the facility on September 14, 2012, with diagnoses including Anemia, Heart Failure, Hypertension and Dementia. Medical record review a Physician's recapitulation orders dated December 1, 2012, revealed, " ...Albuterol...three times a day..." Observation of resident #25 in the resident's room on December 10, 2012, at 12:10 p.m., revealed a nebulizer mask in place with medication inside and no licensed staff in the room. Continued observation revealed the nebulizer mask around the resident's mouth and turned to the on position with no staff in view of the resident.	F 176	**How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** Effective 12/11/12, Resident #25 is now receiving a MD prescribed nebulizer treatment with a licensed nurse supervising resident until nebulizer treatment was completed. **How will the facility identify other residents as having the potential to be affected by the same deficient practice?** The SDC and DON will conduct education for licensed staff on the need to remain with residents receiving nebulizer treatments. Unless they have been assessed to meet criteria to safely self-administer their nebulizer treatment.	01/15/2013

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 9GH821 Facility ID: TN1502

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F 176	Continued	F 176 continued	**What measures will be put in place or systemic changes made to ensure that deficient practice will not recur?** Education of above target audiences will be complete by 1/15/13. Any staff member not completing education by this date will complete prior to next scheduled shift. Unit manager will observe 2 MD prescribed Nebulizer treatments per week for 4 weeks then 2 per month for two additional months to assure that the licensed nurse remains with resident throughout the entire treatment. **How will the facility monitor its corrective actions to ensure that deficient practice will not recur?** Findings will be reported to the Quality Assurance Performance Improvement (QAPI) committee for a period of three months or until substantial compliance is determined by the QAPI committee.	01/15/2013

Interview at the 300 hall nurse's station on December 10, 2012, at 12:35 p.m., with Registered Nurse (RN) #1 at the nurse's desk confirmed the RN started the medication and left the room while the medication was still being administered. Continued interview confirmed the RN was not in sight of the resident while the medication was being administered and the resident had not been assessed for self administration of medications.

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F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a homelike environment related to odors within the facility for one of three resident hallways observed. The findings included: Observation on December 10, 2012, at 11:30 a.m., on the 100 Wing Hallway, revealed a strong urine odor on the front end of the 100 Wing Hallway. Observation on December 11, 2012, at 9:00 a.m., on the 100 Wing Hallway, revealed a lingering smell of urine noted in the front end of the 100 Wing Hallway. Observation on December 13, 2012, at 8:00 a.m., on the front end of the 100 Wing Hallway, revealed a continued lingering smell of urine. Interview on December 13, 2012, at 8:00 a.m., on the front end of the 100 Wing Hallway, with the Director of Nursing (DON) confirmed the lingering smell of urine on the front end of the 100 Wing Hallway. Continued interview revealed "...am not sure what is causing the smell...have changed the mattress for one of the residents and...will change it again..."	F 252	**How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** On 12/13/12 lingering urine odor was noted on the front end of the 100 hallway. The odor of urine has not been noted by residents, family members or staff. The mattress, having been identified as the source of odor, has been changed. **How will the facility identify other residents as having the potential to be affected by the same deficient practice?** Facility rounds were conducted by Ambassadors and Interdisciplinary Team (IDT) to determine if any lingering odors were identified. None were noted. Completed on 13DEC2012. **What measures will be put in place to ensure that deficient practice will not recur?** Ambassador rounds will be conducted daily, Monday through Friday, with reports of any lingering odors to be directed to appropriate personnel to identify and address. The Manager on Duty (MOD) will conduct the same on weekends.	01/15/2013

FORM CMS-2567(02-99) Facility ID: TN00222

(138)

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	445304	A. BUILDING _____ B. WING _____	12/14/2012

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NEWPORT HEALTH AND REHABILITATION CENTER	136 GENERATION DRIVE NEWPORT, TN 37821

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		F 252 continued	Education will be conducted by the Staff Development Coordinator, DON, and/or Administrator on the identification of a lingering odor to be directed to appropriate personnel to identify and address. This will be completed be 15JAN13. Any staff not having completed this training must complete prior to working the next scheduled shift. **How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** The results will be reported to the Quality Assurance/ Performance Improvement (QAPI) committee.	01/15/2013

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	445924	A. BUILDING _____ B. WING _____	12/14/2012

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NEWPORT HEALTH AND REHABILITATION CENTER	130 GENERATION DRIVE NEWPORT, TN 37821

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F 253 SS=D	C/O #29101 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain a sanitary environment for one (#87) of forty residents reviewed. The findings included: Resident #87 was re-admitted to the facility on June 6, 2012, with diagnoses including Diabetes Mellitus with Bilateral Above the Knee Amputations, Hypertension, and Depression. A random observation in the resident's room, during a medication pass, on December 11, 2012, at 1:00 p.m, revealed resident #87 eating from a lunch tray from the bedside table. The meal tray was set up by staff, and was placed in the center of the bedside table. To the left of the meal tray, on the table, was a urinal with approximately 300cc (cubic centimeters) of urine in the container. Interview with the Director of Nursing (DON) on December 11, 2012, at the time of the observation, confirmed the urinal was not emptied and removed from the bedside table, prior to the resident's meal tray being served.	F 253	**How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** The urinal was removed and the overbed table was sanitized. DON educated resident at that time that used urinals should not be placed on eating surfaces at mealtime. A holder for the urinal is located at the bedside for this purpose. He was then encouraged to notify a member of nursing when the urinal needed to be emptied. **How will the facility identify other residents as having the potential to be affected by the same deficient practice?** Audits were conducted by nursing management on 12/13/12 to ensure that residents with urinals have holders available at bedside. Staff will provide education to residents concerning the use of bedside holders for urinals during mealtime and need to place urinals in holder during mealtime.	01/15/2013

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 9GH21 Facility ID: TN0002

(13)

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		F 253 continued	**What measures will be put in place to ensure that deficient practice will not recur?** Ambassadors will conduct rounds (Mon thru Fri) and "Managers on Duty" (Sat and Sun) to ensure that residents are not placing urinals on overbed tables during mealtimes. If Urinals are found on bedside table during mealtime, removal and cleaning is to be done. Resident will again be encouraged to use holders rather than overbed tables for urinals during mealtime. SDC will provide education to licensed nurses and resident care specialists concerning the use of bedside holders for urinals during mealtime and need to place urinals in holder during mealtime. This education will be completed by 15JAN2013. Any staff not having completed this training must complete prior to working their next scheduled shift. **How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** Findings will be reported to the Quality Assurance Performance Committee (QAPI) for a period of three months or until substantial compliance is determined by the QAPI committee.	01/15/2013

(B)

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F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	**How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** Resident #47 had a full pain assessment done by DON on 12/31/12. MD was contacted and orders were received. Resident #103 had a Bowel and Bladder (B & B) Assessment done to reflect current status with care plan updated as indicated by Unit Manager on 12/13/12. Resident #125 is no longer in the facility. **How will the facility identify other residents as having the potential to be affected by the same deficient practice?** Members of nursing management will audit December 2012 MARS to identify residents who have routine pain management and have received prn pain medication to ensure pain assessment has been completed and MD has been contacted for orders as indicated for residents to achieve adequate pain control.	01/15/2013

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	This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview the facility failed to complete pain assessments for one (#47) failed to update a Bowel and Bladder assessment, with a change in condition, for one (#103), and failed to complete a care plan to address Bowel and Bladder status for one (#125) of forty residents reviewed. The findings included: Resident #47 was readmitted to the facility on December 6, 2012, with diagnoses including Hypertension, Diabetes, Knee Replacement, Depression, and Chronic Pain Syndrome. Interview with the resident, in the resident's room, on December 12, 2012, at 8:00 a.m., confirmed the resident received routine pain medications but occasionally had to request more medications due to the routine medications not controlling the pain. Medical record review revealed a physician's orders for Lortab 10/325 mg.(milligram) three times daily and Norco 5/325 mg, every six hours PRN (as needed). Review of the medication administration record (MAR) revealed the resident received PRN medications on December 11, and 12, 2012 in addition to the routine pain medication. Review of the facility's Pain Management policy revealed, "Residents will be screened for pain by using the Monthly Summary (Briggs) and the Pain Evaluation Form...Additionally any resident report of inadequate pain control ...will have a full evaluation of the pain conducted using the Pain	F 272	Members of nursing management will complete audits on current residents to validate that B & B Assessments are current and care plans are updated to reflect the current status of the resident to include an individualized toileting plan as indicated. This will be complete by 1/15/13. **What measures will be put in place or systemic changes made to ensure that deficient practice will not recur?** Licensed nurses will be educated by the Staff Development Coordinator and Director of Nursing. The education will include the following: 1. When administering a prn pain medication, the licensed nurse will record the drug administration and the pain level using the Wong-Baker FACES 1-10 rating scale; Pharmacological interventions attempted; Non-pharmacological interventions attempted. 2. Licensed nurse will reassess prn pain medication effectiveness using the Wong-Baker FACES 0-10 rating scale.	01/15/2013

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 8GH811 Facility ID: TN1602

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F 272	Continued . Evaluation Form. The Licensed Nurse when administering scheduled or routine pain medications, will record the drug administration and the following information on the MAR: Pain level using the Wong-Baker FACES 0-10 rating scale, ...The Licensed Nurse when administering PRN pain medications will record the drug administration and the following on the MAR: Pain level using the Wong-Baker FACES 0-10 rating scale; Pharmacological interventions attempted; Non-pharmacological interventions attempted." Medical record review revealed a Pain Evaluation was completed on December 6, 2012, and revealed, "...Intensity (Resident rates Pain/Hurting on scale 0-10) Worst pain/hurting rated at 8 and Best pain/Hurting rated at 2..." Medical record review revealed no further pain assessment using the "Faces 0-10" had been completed. Interview with the Director of Nursing in the Conference room on December 13, 2012, at 08:00 a.m., revealed the pain rating scale FACES 0-10 is to be kept on the MAR and the nurses are to have the resident "rate" their pain level and document the answer. Further interview confirmed the resident's pain level was not being assessed and was unaware the resident was requiring PRN medications. Resident #126 was admitted to the facility on July 12, 2012, with diagnosis including Cerebrovascular Accident, Aphasia, and Hypertension. Medical record review of the resident plan of care dated July 30, 2012, revealed no documentation of resident bowel and bladder incontinence.	F 272	3. Any resident receiving routine pain management and requiring prn analgesia will have pain assessment completed using the PRN pain management flow sheet and the MD will be contacted as indicated for new orders. This information will be communicated on the 24-hour report. The Director of Nursing/Unit Managers will randomly audit 5 residents who receive routine pain medication per unit weekly for 4 weeks, then 5 residents per unit monthly for 2 additional months, to assure adequate pain control is achieved and MD contacted appropriately. Re-education will occur as indicated. Licensed Nurses will be educated by the Staff Development Coordinator and Director of Nursing. The education will include the following: 1. Bowel and Bladder Assessments (B & B) are to be completed on admission, quarterly, annually, and with significant change. The care plan is to be update to address B & B status according to the assessment.	01/15/2013

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445504	A. BUILDING _____ B. WING _____	12/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT HEALTH AND REHABILITATION CENTER	135 GENERATION DRIVE NEWPORT, TN 37821

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F 272	Continued Continued record review revealed no documentation to reflect specific goals and interventions to address incontinence. Interview with the facility Minimal Data Set (MDS) coordinator on December 12, 2012, at 10: 24 a.m., in the MDS office, confirmed the resident's care plan did not address incontinence. Resident #103 was admitted to the facility on January 13, 2012, with diagnoses including Hypertension, Dementia with Behavoiral Disorder, and Cerebral Vascular Accident. Medical record review of the resident's Bowel and Bladder (B&B) Training assessment, dated September 18, 2012, revealed the resident was readmitted to the facility on August 28, 2012, following an acute hospitalization related to a Cerebral Vascular Accident. The B & B assessment indicated the resident was comatose and incontinent of bowel and bladder when readmitted to the facility. The assessment concluded the resident was not a candidate for B & B retraining in a comatose state. Observation on December 12, 2012, at 4:20 p.m., revealed the resident resting on the bed, in the resident's room, a protective incontinence pad was under the resident. Observation on December 13, 2012, at 9:05 a.m., revealed the resident sitting in a geri-chair near the 200 hall nurse's station. The resident was alert but confused, and unable to participate in a resident interview. Interview with the Unit Manager, on December 13, 2012, at 9:33 a.m., at the 200 hall nurse's	F 272	2. When resident has a change of condition, the B & B Assessment is to be evaluated to assure that the current status of the resident is reflected and updated as indicated. 3. The change of condition information is communicated on the 24-hour report. Education will be complete by 1/15/13. Any nurse not completing education will complete prior to next scheduled shift. The Director of Nursing will audit 5 residents per week for 4 weeks, then 5 residents monthly for 2 additional months, who have Bowel and Bladder Assessment completed according to the MDS schedule or noted change of condition per 24 hour report to assure the assessment and care plan reflects the current B & B status of the resident. R-education will occur as indicated. **How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** Findings will be reported to the Quality Assurance Performance Improvement (QAPI) committee for a period of 3 months or until substantial compliance is determined by the QAPI committee.	01/15/2013

(P8)

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	445504	A. BUILDING _____ B. WING _____	12/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT HEALTH AND REHABILITATION CENTER	138 GENERATION DRIVE NEWPORT, TN 37821

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F 272	Continued station, confirmed the resident's physical condition and level of consciousness had improved since the September 18, 2012 assessment. Continued interview revealed the facility failed to reassess the resident for continence retraining to promote and/or maintain normal bladder function, when the resident's medical condition improved.	F 272		01/15/2013

BK

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, the facility failed to update the care plan for one resident (#149) of forty residents

How will corrective action be accomplished for those residents found to be affected by the deficient practice?
The care plan for resident # 149 was updated to include the skin tear and the interventions.

How will the facility identify other residents as having the potential to be affected by the same deficient practice?
Audits are to be completed on 15JAN2013 for any other residents with injury to assure that updates to care plans have occurred.

What measures will be put in place to ensure that deficient practice will not recur?
In-service on completion and updating of care plan was completed by SDC on 13DEC2012 for licensed nursing staff. Random audits will be conducted on care plans to insure that updates are occurring.

How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?
Findings will be reported to the QAPI committee for a period of three months or until substantial compliance is determined by the QAPI committee.

01/15/2013

(18)

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	445804	A. BUILDING _____ B. WING _____	12/14/2012

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F 280	Continued			01/15/2013

reviewed.

The findings included:

Resident #149 was admitted to the facility on November 29, 2012, with diagnoses including Alzheimer's Dementia, Hypertension, and Anxiety Disorder.

Medical record review of a facility fall investigation dated December 2, 2012, revealed the resident had a fall with a skin tear to the left elbow.

Medical record review of the care plan dated December 3, 2012, revealed the care plan did not address the resident's skin tear to the left elbow.

Observation and interview with the Director of Nursing (DON), in the resident's room, on December 12, 2012, at 10:32 a.m., revealed the resident sleeping in bed with a healing skin tear to the left elbow.

Interview with Minimum Data Set (MDS) coordinator # 1 on December 12, 2012, at 3:05 p.m., confirmed the facility failed to update the care plan to include interventions and treatment for the skin tear.

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NEWPORT HEALTH AND REHABILITATION CENTER	130 GENERATION DRIVE NEWPORT, TN 37821

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F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview, the facility failed to develop a care plan to meet the needs for dialysis for resident (#128) and failed to administer a medication per physician order for one resident (#150) of forty residents reviewed. The findings included: Resident #128 was readmitted to the facility on November 29, 2012, with diagnoses including Chronic Renal Failure, Hypertension, and Dialysis. Review of the resident's Initial Plan of Care dated November 29, 2012, revealed Dialysis had not been identified as a problem with interventions put in place. Interview with the Director of Nursing in the conference room, on December 12, 2012, at 8:00 a.m., confirmed the resident's Initial Plan of Care did not address Dialysis. Resident # 150 was admitted to the facility on December 3, 2012, with diagnoses including Coronary Artery Disease, Anemia, and Hypertension.	F 281	**How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** Care plan was developed for resident # 128. Order for CoQ 10 was clarified and obtained to administer 100mg of CoQ 10 per day. **How will the facility identify other residents as having the potential to be affected by the same deficient practice?** Initial care plans will be reviewed for completeness by nursing management during morning clinical care meeting. Audits of MAR will be conducted by nursing management for availability and dosing. MAR will be reviewed by licensed nurses during each change of shift for medication availability. **What measures will be put in place to ensure that deficient practice will not recur?** An in-service will be completed by the SDC on or before 15JAN2013 to include the five rights of medication administration and the procedures for ordering and obtaining medications.	01/15/2013

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F 281	Continued Medical record review of the Physician recapitulation orders dated December 6, 2012, revealed "...Co - q - 10 (coenzyme) 200 mg (milligrams) every other day..." Continued review of the current medication administration record (MAR) revealed "...Co - q- 10 200 mg initialed December 7- 9,2012 (indicating three doses given concurrently)..." Observation and interview on December 11, 2012, at 8:16 a.m., revealed charge nurse #3 administering medications to resident # 150. Continued observation revealed the charge nurse obtained a bottle of Co - q -10 75 mg and administered to the resident. Interview with the charge nurse confirmed the 75mg was given instead of the 200mg ordered dose. Interview with the Director of Nursing, in the DON office, on December 13, 2012, at 1:05 p.m., confirmed the facility failed to administer the correct dosage and frequency per Physician order. .	F 281 continued	**How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** Findings will be reported to the QAPI committee for a period of three months or until substantial compliance is determined by the QAPI committee.	01/15/2013

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6GH821 Facility ID: TN1502

(18)

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	445504	A. BUILDING _____ B. WING _____	12/14/2012

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F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to complete an assessment and develop an individualized toileting plan for two residents (#103, #125) of forty residents reviewed. The findings included:	F 315	**How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** Resident # 125 had been discharged at the time of review. The unit manager on 12/13/12 updated the Bowel and Bladder (B&B) assessment on Resident # 103 to reflect current status. **How will the facility identify other residents as having the potential to be affected by the same deficient practice?** An audit on current residents will be completed by nursing management on 1/15/2013 to assure that bowel and bladder assessments are completed and in place. Updates or completions will be communicated to the MDS team and care plans will be updated.	01/15/2013

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	445504	A. BUILDING _____ B. WING _____	12/14/2012

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F 315	Continued	F 315		01/15/2013

Resident #125 was admitted to the facility on July 12, 2012, with diagnoses including Cerebrovascular Accident, Aphasia, and Hypertension.

Medical record review of the resident's minimum data set (MDS) dated July 19, 2012, revealed a brief interview for mental status (BIMS) score of 9 indicating moderately impaired cognition. Continued medical record review of the MDS revealed resident usually understood and usually understands. Further review of the MDS revealed resident was frequently incontinent of urine.

Medical record review of the resident's first Bowel Evaluation and Bladder Evaluation dated October 14, 2012, revealed an incomplete evaluation. Medical record of the MDS dated October 16, 2012, revealed resident was always incontinent of urine.

Interview with Director of Nursing (DON), in the DON office, on December 13, 2012, at 1:02 p.m., confirmed the resident Bowel Evaluation and Bladder Evaluation was incomplete and the resident was not placed on an individualized toileting program.

Resident #103 was admitted to the facility on January 13, 2012, with diagnoses including Hypertension, Dementia with Behavioral Disorder, and Cerebral Vascular Accident.

Medical record review of the resident's Bowel and Bladder (B&B) Training assessment, dated September 18, 2012, revealed the resident was

What measures will be put in place or what systemic changes made to ensure that deficient practice will not recur?

Education will be conducted by the Director of Nurses to the MDS team on the completeness of the bowel and bladder assessment with significant changes.

The education will be completed for the targeted audience by 1/5/13. Any staff not completing the education by this date will complete it prior to their next scheduled shift.

Director of Nursing will audit Significant change assessments weekly times four then 1 time a month for two additional months to insure that Bowel and Bladder assessments reflect the current status of the resident.

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F 315	Continued readmitted to the facility following an acute hospitalization related to a Cerebral Vascular Accident. The B & B assessment indicated the resident was comatose and incontinent of bowel and bladder when readmitted to the facility. The assessment concluded the resident was not a candidate for B & B retraining in a comatose state. Observation on December 12, 2012, at 4:20 p.m., revealed the resident resting on the bed, in the resident's room. Continued observation revealed a protective incontinence pad had been placed under the resident. Observation on December 13, 2012, at 9:05 a.m., revealed the resident sitting in a geri-chair, near the 200 hall nurse's station. The resident was alert but confused, and unable to participate in a resident interview. Interview with the Unit Manager, on December 13, 2012, at 9:33 a.m., at the 200 hall nurse's station, confirmed the resident's physical condition and level of consciousness had improved since the September B & B assessment. Continued interview revealed the facility failed to implement a bladder retraining program to promote and/or maintain normal bladder function, when the resident's medical condition improved.	F 315	How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? Findings will be reported to the (QAPI) committee for a period of three months or until substantial compliance is determined by the QAPI committee.	01/15/2013

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F 356 SS=D	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.		**How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** The staffing form was updated on 12/13/12 to reflect the facility name, current census, date, and the total number of hours worked by RN's LPN's and Resident Care Specialist. **How will the facility identify other residents as having the potential to be affected by the same deficient practice?** No direct affect was noted to residents. **What measures will be put in place or systemic changes made to ensure that deficient practice will not recur?** Unit Managers have been educated by the DON on posting the form to reflect the Facility Name, Current date, census and the requirement to add the projected hours of RN's LPN's, Resident Care specialist with adjustments as necessary. The Unit Manager will retain forms along with the key factor report.	01/15/2013

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6GN121 Facility ID: TN1502

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NEWPORT HEALTH AND REHABILITATION CENTER	136 GENERATION DRIVE NEWPORT, TN 37821

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F 356, Continued	This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post the required staffing information related to the actual hours worked by licensed and unlicensed staff. The findings included: Observation on December 10, 2012, at 10:40 a.m., on the front entrance hallway information board of the facility, revealed the required posted daily staffing. Further observation revealed the actual hours worked information with no information documented. Observation on December 13, 2012, at 9:00 a.m., on the front entrance hallway information board of the facility, revealed the daily staffing with the actual hours worked information and no information documented for the present date. Continued observation revealed the resident census was not documented at the start of the shift. Interview on December 13, 2012, at 10:30 a.m., with the 100 Wing Clinical Manager and the Director of Nursing (DON), in the clinical manager's office, confirmed the required nursing staffing information was not posted at the beginning of the shift.	F 356	The Director of Nursing and/or Administrator will conduct audits twice a week for 4 weeks then once a month for two additional months to assure completeness of forms. **How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** Findings will be reported to the QAPI committee for a period of three months or until substantial compliance has been determined by the QAPI committee.	01/15/2013

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 0GH821 Facility ID: TN1502

(138)

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445504	A. BUILDING _____ B. WING _____	12/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT HEALTH AND REHABILITATION CENTER	135 GENERATION DRIVE NEWPORT, TN 37821

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F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of	F 425	**How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** (a.) A clarification order was obtained from Dr. for the Neurontin 200 mg BID and 300mg at HS for Resident # 73 on 12/11/2012 by unit manager. (b.) A clarification order was obtained from Dr. for the CoQ-10 to be 100mg daily on resident # 150. (c.) Kadian is now being administered to Resident # 22 as ordered by MD.	01/15/2013

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 8GH11 Facility ID: TN1502

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F 425	Continued: a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, facility policy review, and interview the facility failed to ensure two residents (# 22 & #150) received medications as ordered, and failed to ensure accuracy of a physician order sheet for one resident (#73) of forty residents reviewed. The findings included: Resident #73 was admitted to the facility on January 18, 2012, with diagnoses including Diabetes Mellitus, Anxiety, and Neuropathy. Medical record review of physician recapitulation orders for October 2012, revealed "...neurontin (medication for seizures) 200 mg twice a day...neurontin 300 mg...at bedtime..." Continued medical record review of the physician recapitulation orders for November 2012, revealed the neurontin 200 mg twice a day was not carried over on the November order sheets. Medical record review of the resident's medication administration record for November and December revealed the facility continued to give the medication as stated on the October physician recapitulation orders. Interview with the resident's physician on	F 425	**How will the facility identify other residents as having the potential to be affected by the same deficient practice?** An audit of December MARS was conducted by members of nursing management and consultant pharmacist to assure that Physician Order Sheets are accurate. Clarification orders were obtained as indicated. This audit was completed by Dec 31. Audits of residents receiving CO Q 10 will be conducted by members of nursing management to assure availability and proper dosing. This will be complete by 1/4/13. Residents who receive Kadian will be audited by members of nursing management to assure that medication is available and being administered per order. This will be complete by 1/4/13. **What measures will be put in place or systemic changes made to ensure that deficient practice will not recur?** Education will be conducted by Staff Development coordinator (SDC) for licensed nurses on medication	01/15/2013

(28)

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	445504	A. BUILDING _____ B. WING _____	12/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT HEALTH AND REHABILITATION CENTER	185 GENERATION DRIVE NEWPORT, TN 37821

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F 425	Continued December 12, 2012, at 2:20 p.m., at the 300 hall nurse's desk, revealed the physician wanted the resident to receive the neurontin 200 mg twice a day as given. Interview with the Director of Nursing (DON), in the DON office, on December 13, 2012, at 1:10 p.m., confirmed that the pharmacy was responsible for checking the physician orders and failed to ensure the accuracy of the November physician orders. Resident # 150 was admitted to the facility on December 3, 2012, with diagnoses including Coronary Artery Disease, Anemia, and Hypertension. Medical record review of the Physician recapitulation orders dated December 6, 2012, revealed "...Co - q - 10 (coenzyme) 200 mg (milligrams) every other day..." Continued review of the current medication administration record (MAR) revealed "...Co - q- 10 200 mg initialed and circled December 4- 6, 2012, indicating three days the medication was unavailable. Medical record review of the facility policy for Alternate Pharmacy Services revealed "...each facility will have an alternate local pharmacy provider to ensure that all ordered medications are available as needed..." Interview with the facility central supply nurse on December 11, 2012, at 3:05 p.m., revealed the central supply nurse had not been notified of the order. Interview with the Director of Nursing, in the DON	F 425	management that will include process for ordering and receiving medications, to notify the physician and to notify the pharmacy and request that medication be sent from the backup. Education will be completed by 1/15/13. Any licensed nurse not completing education will complete prior to next scheduled shift. Members of nursing management who are responsible for end of month changeover will be educated by the Director of Nursing regarding process to assure that Physician order sheet is complete with current orders. This will be completed by December 31, 2012. Unit Managers/Central Supply LPN/designee will conduct a MAR/CART audit weekly for 4 weeks then monthly for 2 additional months to assure availability of meds. MARS will be audited weekly for 4 weeks then monthly for 2 additional months to assure that there are no circled meds due to unavailable meds. Re-education will occur as indicated.	01/15/2013

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F 425	Continued office, on December 13, 2012, at 1:05 p.m., confirmed the facility failed to obtain the medication per facility policy. Resident #22 was admitted to the facility on October 14, 2003 with diagnoses including Psychosis, Dementia, Gastroesophageal Reflux Disease (GERD), Hypothyroidism, Depression, Anxiety, Osteoarthritis (OA), Gout and Degenerative Joint Disease (DJD). Medical record review of the quarterly Minimum Data Set (MDS), dated November 9, 2012, revealed the resident scored an eleven on the Brief Interview for Mental Status (BIMS), indicating the resident was moderately cognitively impaired. Review of the Medication Administration Record (MAR), dated December, 2012, revealed the resident was receiving Kadian (medication for pain) 140 mg (milligrams) every morning. Continued review revealed the medications were split into 100 mg packages and 20 mg packages (resident was to receive 2 tablets of the 20 mg dose for a total of 40 mg). Continued review of the MAR revealed the 20 mg tablets were circled (indicating the dose was not given to the resident). Further review revealed the resident did not receive the 20mg tablets (40mg) on December (2,3,4,5,6,7,8,9,10,11) 2012 (10 days). Medical record review revealed a prescription signed by the physician, dated December 10, 2012, "...Kadian CR 20mg, two (40 mg), po (by mouth) with 100 mg = 140 mg..." Medical record review of the resident's care plan,	F 425	Members of nursing management will complete end of month changeover. A copy of the corrected physician order sheet will be sent to pharmacy for updating for the next month's changeover. The pharmacy consultant will randomly select 10 physician order sheets monthly for three months to validate accuracy of physician order sheet and report results to the Director of Nursing and/or Administrator. **How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** Findings will be reported to the Quality Assurance Performance Improvement committee (QAPI) for a period of three months or until substantial compliance is determined by the QAPI committee.	01/15/2013

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F 425	Continued last updated November 13, 2012, revealed "...meds (medications) as ordered for pain in shoulders, elbows, knees, ankles and left great toe...pain related to OA, DJD and Gout..." Observation on December 12, 2012, at 9:20 a.m., in the resident's room, revealed the resident lying on the bed sleeping. Interview on December 12, 2012, at 4:25 p.m., with Registered Nurse (RN) #1, in the 300 Wing Nurses Station Medication room, revealed the resident has continuous pain to his shoulders and left great toe. Continued interview revealed the resident takes the Kadian and Lortab (medication for pain) and the resident takes the Lortab (10/500 mg) every six hours as needed. Interview on December 13, 2012, at 7:15 a.m., with the 100 Wing Clinical Manager, in the 300 Wing Nurses Station, revealed "...the medication was not available and the resident received the 100 mg on December (2,3,4,5,6,7,8,9,10,11) 2012, but did not get the 20mg (x2) on those days...notified the pharmacy on December 3, 2012 and told them the resident was out of 20mg tablets...there was a prescription faxed to the pharmacy on December 10, 2012 and signed by the physician..." Telephone interview on December 13, 2012, at 8:15 a.m., with a Pharmacy Technician from the facilities consulting pharmacy, revealed the pharmacy filled the prescription on November 16, 2012 for fifteen days. Continued interview revealed "...was waiting on a new prescription for the medication and never received it...normally the pharmacy faxes the new order for the facility	F 425		01/15/2013

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F 425	Continued to get the physician to sign and the facility sends it back to us for the medication to be filled...the medication was refilled on December 9, 2012 from the pharmacy..." Review of the facility policy, Ordering and Receiving Medications from Pharmacy Provider, dated April, 2007, revealed "...repeat medications (refills) are keyed into Facility link under Reorder/Refill or the reorder label can be attached to a piece of paper and faxed to the pharmacy...reorder medication (three to four) days in advance of need to assure and adequate supply is on hand...when ordering medication that requires special processing (such as Schedule 2 controlled substances) order at least (seven days) in advance of need..." Interview on December 13, 2012, at 7:15 a.m., with the 100 Wing Clinical Manager, in the 100 Wing Nurses Station, confirmed the resident did not receive the 20 mg tablets (x2) for a total of 40 mg for 10 days and the facility failed to provide pharmaceutical services for the resident.	F 425		01/15/2013

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	440304	A. BUILDING _____ B. WING _____	12/14/2012

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F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441	How will corrective action be accomplished for those residents found to have been affected by the deficient practice? (a.) Education was conducted by the SDC on 12/10/12 for the Resident Care Specialist (RCS) on the importance of proper hand hygiene in the prevention of infection. This education stressed that hands must be washed or alcohol based rub used after filling each ice pitcher. (b.) Ice cart was taken to the dietary department for cleaning. Education was conducted to the dietary department by the Dietary Manager regarding the cleaning schedule for ice carts. Licensed Nurses and Resident Care Specialist were educated on the importance of hand hygiene on 12/10/12 and 12/11/12. They were instructed to notify dietary staff if ice cart needs cleaning. (c.) Soiled dishes were removed from dining room and no further issues were noted.	01/15/2013

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 842421 Facility ID: TN002

(28)

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F 441	Continued (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policy, the facility failed to maintain standard infection control practice related to failure to wash or sanitize the hands during ice pass for two resident rooms observed; failed to ensure standard infection cleaning of the ice cart for one of three ice carts; failed to remove contaminated breakfast foods from the dining area prior to the lunch dining observation; and failed to maintain a clean environment in the	F 441	Dietary Manager instructed dietary staff to do a visual check of the dining room prior to serving meal trays to the residents. SDC instructed nursing staff to do a visual check of dining room to assure there are no soiled dishes prior to serving trays. (d) Shower room was cleaned by nursing staff and housekeeping staff was called for deep cleaning of shower room. Education was conducted for RCS's that included the requirement that shower rooms must be cleaned between residents and after resident use. Education was conducted by the Housekeeping Supervisor with housekeeping staff that shower rooms are to be deep cleaned after morning showers and again after lunch.	01/15/2013

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F 441	Continued From page 23 shower room on the 100 Wing Hallway for one of two shower rooms on the 100 Wing Hallway. The findings included: Observation on December 10, 2012, at 10:45 a.m., during the initial tour of the facility, on the 300 Wing Hallway, revealed CNA (Certified Nurse Assistant) #1, passing ice on the 300 Wing Hallway. Continued observation revealed the CNA entered and exited two rooms on the hallway with the ice pitcher, filled the pitchers with ice, reentered the rooms, filled the ice pitcher with water, placed the ice pitchers on the bedside and exited the rooms and failed to wash or sanitize the hands prior to entering and exiting the rooms. Interview with the CNA on December 10, 2012, at 10:55 a.m., on the 300 Wing Hallway, confirmed the CNA failed to wash or sanitize the hands between entering and exiting the rooms after filling the ice pitchers and returning the pitchers to the rooms. Review of the facility policy, Hand Hygiene, with a revision date of 2009, revealed "...If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all clinical situations..." Interview on December 10, 2012 at 11:00 a.m., with Registered Nurse (RN) #1, on the 300 Hallway, confirmed the CNA failed to wash or sanitize the hands during ice pass and failed to follow standard infection practice. Observation on December 10, 2012, at 10:45 a.m., on the 300 Wing Hallway, during the ice	F 441	**How will the facility identify other residents as having the potential to be affected by the same deficient practice?** Random observations will be conducted to assure that infection control procedures are being followed. **What measures will be put in place or systemic changes made to ensure that deficient practice will not recur?** (a.) Hand hygiene observations will be conducted at random by SDC, DON, Unit Managers or designee to assure that proper procedures are being followed. (b.) Random inspection of ice carts will also be conducted by Dietary Manager, DON, SDC or designee. (c.) Random audits will be conducted to assure that no soiled dishes are in dining room when trays are served.	01/15/2013

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F 441	Continued :	F 441		

pass, revealed a ice cart with three shelves. Continued observation revealed the second shelve with four cup holders on the shelf and two of the holders had a dried red substance inside of the holder.

Interview on December 10, 2012, with the Certified Nurse Assistant (CNA) #1, on the 300 Wing Hallway, confirmed the cup holders had a dried red substance inside of cup holder and the cup holders were dirty. Continued interview revealed the CNA was not sure who cleaned the ice carts and the CNA "...get the carts from the kitchen prior to passing ice..."

Observation and interview with the Director of Nursing (DON) on December 10, 2012, at 12:00 p.m., in the dining room, confirmed the ice cart cup holders had a dirty dried red substance inside the cup holder and the ice carts were used for passing ice to the residents.

Observation on December 10, 2012 at 12:05 p.m., in the dining room, during the lunch dining room observation, revealed a bedside table in the dining room with one bowl of half filled contaminated oatmeal with a spoon inside the bowl and two coffee cups half full of coffee.

Interview with the Speech Therapist on December 10, 2012, at 12:05 p.m., in the dining room, confirmed the bowl of oatmeal and the two coffee cups were left over from breakfast and were not removed from the dining room prior to serving lunch.

Observation of December 12, 2012 at 1:40 p.m., in shower room #1 on the 100 hallway, revealed

F 441

(d.) Random audits of shower rooms will be conducted by SDC, DON, Unit Managers, Housekeeping Supervisor or designee to assure that shower rooms are clean.

How will the facility monitor its corrective actions to ensure that the deficient practice does not recur?

Findings will be reported to the QAPI committee for a period of three months or until substantial compliance has been determined by the QAPI committee.

01/15/2013

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445504	A. BUILDING _____ B. WING _____	12/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT HEALTH AND REHABILITATION CENTER	135 GENERATION DRIVE NEWPORT, TN 37821

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F 441	Continued From page 25 brown loose debris at the drain in the shower room. Continued observation revealed a brown substance on the outside of the commode and on the trash liner beside the commode. Interview on December 13, 2012, at 1:40 p.m., with the Director of Nursing (DON), in the shower room #1, on the 100 Wing Hallway, confirmed the brown loose debris at the drain in the shower room, a brown substance on the outside of the commode and a dried brown substance on the trash liner beside the commode. Continued interview with the DON revealed there was a smell of bowel in the shower room and the staff had not cleaned the shower room.			01/15/2013

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F 460 SS=D	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY	F 460		

Bedrooms must be designed or equipped to assure full visual privacy for each resident.

In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview the facility failed to provide full visual privacy for two residents (#30 & #148) of forty residents reviewed.

The findings included:

Observation in the resident room on December 11, 2012, at 11:12 a.m., revealed resident # 30's privacy curtain with several broke plastic hooks to support the privacy curtain. Continued observation of resident #148's privacy curtain revealed several broke plastic support hooks and a support hook preventing the privacy curtain from sliding forward.

Observation and interview with the facility maintenance director on December 11, 2012, at 11:18 a.m., confirmed the privacy curtains were not functional to provide full privacy for the two residents.

How will corrective action be accomplished for those residents found to have been affected by the deficient practice?
On 12/11/12 the Maintenance Director repaired the privacy curtain of Resident # 30. Broken plastic support hooks were removed and new ones installed. This assured that curtain could be pulled freely around bed so that full visual privacy was achieved.

How will the facility identify other residents as having the potential to be affected by the same deficient practice?
On 12/11/12, during survey, an audit of all privacy curtains throughout the facility was completed. Any curtains found not functioning correctly were repaired or replaced by Maintenance Director or housekeeping staff.

01/15/2013

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		F 460	**What measures will be put in place or systemic changes made to ensure that the deficient practice does not recur?** Housekeeping staff, nursing staff, therapy staff and ambassadors have been educated by SDC or designee to ensure that privacy curtains are in working order so that full visual privacy can be assured. All staff has been instructed to report mechanical issues with the privacy curtains to Maintenance Director and to report curtains that are not long enough to surround the bed to the Housekeeping Supervisor so that a new one can be hung. Ambassador rounds (Mon – Fri) and Manager-on-Duty Rounds (Sat-Sun) will include observation of privacy curtains with any issues to be reported to the appropriate party. **How will the facility monitor its corrective actions to ensure that the deficient practice does not recur?** Findings will be reported to the QAPI committee for a period of three months or until substantial compliance is determined by the QAPI committee.	01/15/2013

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: [illegible] Facility ID: [illegible]

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F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a nursing call system for two (#107 & #69) of forty sampled residents The findings included: Observation and interview, in the resident's room, with the Social Worker on December 11, 2012, at 10:00 a.m., revealed resident #107's bedside call light wire had been cut. Interview at that time confirmed the resident's call light was not in functioning order. Observation and interview, in the resident #69's room, with Licensed Practical Nurse (LPN #1) on December 11, 2012, at 10:30 a.m., revealed the resident's bedside call light could not be activated. Interview with the LPN at that time confirmed the resident's call light was not in functioning order.	F 463	**How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** The call lights were replaced for Residents # 107 & # 69 and are in working order. This was completed on 11DEC2012. **How will the facility identify other residents as having the potential to be affected by the same deficient practice?** An audit was completed on 12/28/12 by management staff. All call lights in the building were reviewed to insure they were functioning properly. **What measures will be put in place or systemic changes made to ensure that deficient practice will not recur?** Education was given to Ambassadors on checking of call lights for proper functionality during Ambassador Rounds (Mon–Fri) and MOD Rounds (Sat-Sun). They were instructed to report any issues with the functionality of call lights to the Maintenance Director for correction. Extra call light cords are available in central supply and med room for after hours or weekend availability. **How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** Findings will be reported to the QAPI committee for a period of three months or until substantial compliance is determined by the QAPI committee.	01/15/2013

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: WGH921

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F 520 SS=D	483.75(e)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of Quality Assessment and	F 620	**How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** On 12/13/12 the Medical Director was contacted in reference to her lack of signing-in at the monthly Quality Assurance Meetings. She constructed a letter verifying her attendance at said meetings. This letter was then faxed to the Dept of Health as verification of her attendance. **How will the facility identify other residents as having the potential to be affected by the same deficient practice?** On 12/13/12, it was determined that no residents had the potential to be harmed by the Medical Director being in attendance and failing to sign-in to the monthly Quality Assurance Meeting.	01/15/2013

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6GHN11 Facility ID: TN1622

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F 520	Continued Assurance (QAA) sign-in sheets, observation and interview, the facility failed to ensure the required sign-in of the designated physician at the monthly QAA meetings for one of six monthly meetings reviewed. The findings included: Review of the facilities QAA sign-in sheets for May, June, July, September, October and November, 2012, revealed the designated physician had not signed the facilities sign-in sheet indicating his/her attendance at the monthly QAA meetings. Observation on December 9, 2012 and December 13, 2012, revealed the facilities medical director was in the facility making rounds for the residents. Interview with the Administrator on December 13, 2012, at 2:00 p.m., in the administrator's office, revealed the facility meets on a monthly basis for QAA. Further interview with the administrator confirmed the designated physician failed to sign the facilities QAA sign-in sheets for May, June, July, September, October and November 2012. Further interview revealed the physician was in the building on December 13, 2012.	F 520	**What measures will be put in place or systemic changes made to ensure that deficient practice will not recur?** As part of the agenda for future Quality Assurance Meetings, a role call will be read from the list of those in attendance to verify that the Medical Director has, in-fact, signed her name to (at a minimum) the required quarterly meeting. **How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?** The results of the Attendance Verification during the QA Meeting will then be shared with the members of the QA Team quarterly for 12 months. This practice began at the December meeting held on 17DEC12.	01/15/2013

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 9GHI11 Facility ID: TN1502

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